STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

February 22, 2019

John Rodis, M.D., Administrator
St Francis Hospital & Medical Center
114 Woodland Street
Hartford, CT 06105

Dear Mr. Rodis, M.D.:

Unannounced visits were made to St Francis Hospital & Medical Center commencing on December 5, 2018 and concluding on January 28, 2019 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a certification inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits. The state violations cannot be edited by the provider in any way.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by March 4, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

DATES OF VISIT: Commenced on December 15, 2018 and concluded on January 28, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by March 4, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

An office conference has been scheduled for March 20, 2019 at 1:00 P.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting. Please be prepared to discuss those violations identified with an asterisk.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:lst

CT #'s 23053, 24441, 24459

DATES OF VISIT: Commenced on December 15, 2018 and concluded on January 28, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (6).

1. Based on clinical record review, interview and policy review the facility failed to ensure that Oxygen was administered per the physician order and/or that the patient was monitored appropriately. The findings include the following:
   a. Patient #1 was admitted to the facility on 10/31/18 for surgical removal of a left hip cyst. The patient had a history of Diabetes, congestive heart failure, chronic kidney disease, syncope, hypertension and paroxysmal atrial fibrillation. The H&P completed on 10/31/18 indicated that the patient "uses" oxygen at home.

      The physician order dated 10/31/18 directed Oxygen 3 liters. Review of the nursing flow sheets indicated that on 10/31/18 at 8:53 PM the patient was on 2 liters of Oxygen with a saturation of 97% however the record failed to reflect a corresponding order for the decreased in liter flow.

      In addition the flow sheet indicated that the patient was on 2 liters for the period of 10/31/18 at 8:53 PM through 11/2/18 at 7:41 AM when the liter flow was identified as 3 liters however subsequent documentation on 11/2/18 failed to identify documentation of the liter flow at the time oxygen saturations were obtained. Interview with the Manager on 12/5/18 at 12:15 PM indicated that she thinks that the liter amount being administered should be documented when vital signs are done. The manager indicated that there should be a note when there is a change and/or orders when the liter dose is changed.

      Interview with NA #1 on 12/11/18 at 1:33 PM indicated that the patient requested to go to the bathroom, NA #1 indicated that the patient did not have Oxygen on at that time and she informed the patient she needed to get an oxygen tank. NA #1 stated that the patient indicated that he/she could not wait and was assisted to the bathroom at approximately 9:45 AM. NA #1 indicated that she did not inform the RN that the patient did not have Oxygen on and/or get an oxygen tank.

      Review of the facility policy indicated that Oxygen is a drug, its use requires a physician's order specifying a concentration or liter flow.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1) and/or (i) General (6).

2. Based on clinical record review, interview and policy review the facility failed to follow the facility policy for one patient identified as a high fall risk. The findings include the following:
   a. Patient #1 was admitted to the facility on 10/31/18 for surgical removal of a left hip cyst. The patient had a history of Diabetes, congestive heart failure, chronic kidney disease,

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

syncope, hypertension and paroxysmal atrial fibrillation.
Review of the clinical record indicated that the patient was identified as a high fall risk, assist of 1 to ambulate to the bathroom and that the following interventions were implemented: comfort and safety rounds, fall arm band, fall precautions, door magnet and bed/chair alarm.

Interview with NA #1 on 12/11/18 at 1:33 PM indicated that the patient requested to go to the bathroom and was assisted to the bathroom at approximately 9:45 AM. NA #1 indicated that she was outside the door when someone else called and she left the area, returned and checked on the patient who requested more time in the bathroom. NA #2 stated that she checked on the patient three times and on the fourth time there was no answer, upon entering the bathroom the patient was found slumped on the toilet.

Review of the policy indicated that for patients identified as moderate or high risk the following interventions in part, are to be implemented: remain with the patient while toileting, placement of a yellow wristband, door magnet, and activate bed/chair alarms.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (i) General (6).

3. *Based on clinical record review and interview for 1 (P#5) of 11 patients who underwent interactions with hospital security staff while in the Emergency Department (ED) the facility failed to ensure that the patient was provided care in a safe setting that was free from abuse, and failed to ensure the hospital's Patient Rights policy was followed when an incident of possible abuse was identified. The findings include:
   a. P#5 had diagnoses that included a history of alcohol abuse and chronic foot and shoulder pain and was evaluated in the Emergency Department (ED) on 11/1/18 for a chief complaint of blood in his/her stool for 3 weeks. P#5 was well known to the ED staff, was assessed, cleared medically and discharged.

      According to a hospital security report dated 11/1/18 and substantiated by video monitoring, an altercation had occurred between P#5 and Security Officer SO#1 in the ED waiting area while P#5 was being escorted out of the ED after discharge.

      According to a written statement dated 11/1/18 at 6:11 AM by Registered Nurse (RN) #4 and a subsequent interview on 12/7/18 at 8:55 AM, RN#4 indicated P#5 had been discharged and was escorted out of the ED by Security Officer (SO) #1 and SO #2 (ED Shift Supervisor) to the waiting area. P#5 proceeded to walk to the triage desk agitated, spitting food and demanding a medical cab. SO#1 approached P#5 and P#5 became more agitated. SO#1 was asked to back away by SO#2 multiple times. P#5 became more agitated and swung at SO#1 and SO#1 grabbed P#5. SO#2 and SO#3 attempted to get between SO#1 and P#5 to deescalate the situation. SO#1 did not back off as instructed and the situation escalated again. SO#1 then pushed P#5 against the desk and had his/her hands on P#5's neck. A silent alarm and Code "Grey" was called to triage, the situation

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

deescalated and SO#1 was removed from the area. P#5 was asked if he/she was injured and wanted to be evaluated however P#5 declined. P#5 calmed and was escorted out of the ED without further incident.

During interviews with SO#2 and SO#3 on 12/10/18 they indicated P#5 had been discharged and was in the waiting area requesting a medical cab. He/she was hostile and yelling at the staff as per his/her usual behaviors and it was explained that P#5 was not eligible for a cab because he/she could not provide an address of residence. SO#3 indicated he/she did not understand why SO#1 reacted the way he/she did as SO#1 had escorted P#5 out of the ED many times before without incident and was familiar with P#5's behaviors.

A written report by the Security Supervisor dated 11/1/18 at 8:00 AM indicated after the incident SO#1 was removed from the ED and assigned to another area of the hospital until he/she could be relieved and finish his/her report. The report indicated SO#1 denied any wrong doing and denied he/she put his/her hands on P#5.

The Security Supervisor assigned on 11/1/18 was not available for interview during the investigation.

Review of the hospital security report failed to indicate if local law enforcement were called immediately following the altercation on 11/1/18. A local law enforcement report dated 11/5/18 indicated the Director of Security had contacted the local law enforcement about the altercation. The incident including the video recording was reviewed by local law enforcement however because P#5 had not called police to file a complaint and/or returned to the hospital claiming injuries the report was filed for documentation purposes only.

During a review of the incident with the Director of Security on 12/6/18 at10:15 AM he/she indicated SO#1 should have been escorted out of the building immediately pending an investigation, the Director of Security and Leadership should have been notified and the local law enforcement should have been called. The Director of Security indicated he/she was not notified of the incident immediately and he/she called local law enforcement to report the incident when he/she became aware. Local law enforcement viewed the video and did not view the incident as an assault. The Director of Security indicated SO#1's employment was terminated as a result of the incident.

During a review of the incident with the Clinical Risk Manager on 12/6/18 at 9:10 AM he/she identified escalation via the chain of command used in the event of witnessed abuse or an allegation of abuse had not been implemented. Based on the hospital Patients' Rights policy the expectation was that notification of the incident would have been reported up the chain of command for further direction. The Clinical Risk Manager indicated he/she was on call and did not receive a call about the incident and Risk Management was not notified until the next day.

During an interview with Director of Nurses (DON) on 12/6/18 at 10:45 AM he/she

DATES OF VISIT: Commenced on December 15, 2018 and concluded on January 28, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

indicated after the incident occurred neither the DON and/or Nurse Manager in the ED were notified of the incident.

Hospital Patients' Rights Policy indicated the patient has the right to be free from mental, physical, sexual and verbal abuse, neglect and exploitation during the hospital stay. The policy further directs that staff must report allegations or actual assault or abuse of a patient to their supervisor following chain of command, including Leadership of the area that the incident occurred. Risk Management will be notified who will discuss with the administrative Supervisor to determine next steps including reporting to local law enforcement as appropriate and/or at the patients request.

Note: Review of the hospital Patient Rights policy identified staff guidance in the event of an allegation of abuse. The hospital does not have a separate Abuse policy.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing Service (1) and/or (i) General (6).

4. Based on clinical record review and interview for 1 (P#11) of 4 patients reviewed for use of restraints the hospital failed to ensure medical record restraint documentation was complete and failed to ensure medical record restraint documentation was complete according to hospital policy. The findings include:
   a. P#11 was evaluated in the ED for treatment of substance abuse. According to medical record documentation P#11 was confused, uncooperative, impulsive and physically aggressive. P#11 was placed in 4 point locked restraints on 12/3/18 at 1:00 PM.

      During a review of the medical record with the ED Quality Data Analyst on 12/7/18 it was identified the medical record lacked documentation of a written physician's order for the 4 point locked restraints.

      The hospital Restraint Policy indicated each mechanical restraint or seclusion must be ordered and the order must be in accordance with the identified limits for up to a total of 24 hours.

      During a review of the medical record with the ED Quality Data Analyst on 12/7/18 it was identified the medical record lacked documentation of a physician face to face evaluation within 1 hour of restraint application.

      According to the hospital Restraint Policy a physician or licensed independent practitioner (LIP) must evaluate the patient face to face within 1 hour after the initiation of the restraint.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (3) and/or (e) Nursing Service (1).

5. Based on review of facility documentation, facility guidelines and interview the facility failed to

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

ensure that staffing met facility staffing guidelines. The finding includes the following:

a. Review of the staffing for the Children's/Adolescent unit for the period of 1/6/19 through 1/27/19 indicated that on 5 of 27 days staffing levels failed to meet the facility staffing guidelines. Review of the facility guidelines indicated that for a census of greater than 11 patients the unit will be staffed with 2 registered nurses (RN's) and 2 mental health workers (MHW) on the 11:00 PM to 7:00 AM shift (night shift).

   Review of the staffing sheets with the Nurse Manager on 1/29/19 at 2:30 PM, dated 1/14/19, 1/15/19, 1/16/19 and 1/17/19 indicated that the unit had a census of 12 patients on the night shift and the unit was staffed with 2 RN's and 1 MHW. The unit was staffed with a second MHW however this person was acting as a constant sitter.

   Interview with the Manager on 1/29/19 at 2:30 PM indicated that on the night shift (11:00 PM-7:00 AM) the children's unit typically covers their own constants since the children are sleeping. The Nurse Manager acknowledged that staffing did not meet the identified guidelines for the census.

   Review of the staffing sheet dated 1/9/19 indicated that the unit had a census of 12 and was staffed with 1 RN and 2 MHW's. Review of the staffing sheet dated 1/9/19 indicated that the nursing supervisor called out sick. The staffing sheet indicated that second RN assigned to the Children's unit stepped into the supervisor role leaving the unit short. The staffing sheets indicated that the Supervisor was stationed on the floor as back-up while acting in the supervisor role for the three units.

   Interview with the Manager on 1/28/19 at 2:30 PM indicated that the RN attempted to fill (replace) the call out but was unable. The Manager indicated that she was not notified of the call out and/or that the unit was working short one RN.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Service (1) and/or (i) General (6).

6. *Based on clinical record review, interviews and policy review for 1 of 3 patients with suicidal and/or self-harm tendencies (Patient #21) the facility failed to ensure that staff provided a safe environment when the patient was able to harm self on 5 occasions while on constant observations by swallowing Lithium, banging head on a wall, swallowing a paperclip, swallowing a screw and using hospital socks as a ligature to strangle self. In addition, the facility failed to ensure that safety interventions were identified or implemented and/or that safety policies were clear and appropriate for the population served. The findings include:
   a. Patient #21 presented to the Emergency Department (ED) on 1/2/19 at 6:26 PM with a suicide attempt by sitting in the street waiting to be hit by a car. The patient had a history in

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

part of Post-Traumatic Stress Disorder (PTSD), bipolar disorder, anxiety, asthma, gastric bypass, opiate dependence and stroke. Review of the clinical record indicated that Patient #21 was placed on constant observation at the time of admission to the ED. An RN note dated 1/2/19 at 7:21 PM indicated that she was informed by MD #22 that Patient #21 reported taking a "handful" of Lithium at the time of triage and attempted to take 4 additional but was stopped by the physician. The patient indicated that he/she took a handful prior to admission.

The clinical record indicated that Patient #21's belongings were secured at 6:44 PM. Interview with the triage nurse on 1/29/19 at 11:00 AM identified that the patient came to the ED and was in the line to check in, left the line and then was brought back to the ED by security. The patient was seen in triage, placed in the triage area and constant observation was initiated. Interview with Emergency Department Technician (EDT) #1 who performed constant observation indicated that she had the patient belongings, catalogued, and secured all the items. The clinical record indicated that the patient had multiple pill bottles. The EDT indicated that she did not recall what was in the pill bottles and did not document that at that time.

The ED record indicated that Patient #21's Lithium level was 0.7 mmol/L (normal 0.6 mmol/L) at 8:55 PM and on 1/3/19 at 3:58 AM (7 hours later) the Lithium level was 1.8 mmol/L. The hospital failed to adequately supervise the patient to prevent the consumption of Lithium.

Patient #21 was admitted from the ED to the Stepdown unit for monitoring. Review of the discharge summary dated 1/4/19 indicated that Patient #21's Lithium levels were monitored and normalized without need for intervention. A psychiatric consult evaluation completed on 1/3/19 at approximately 7:30 AM by Psychiatrist #21 indicated that the patient was considered a very poor provocative historian who reports having more than 50 inpatient psychiatric admissions for PTSD, personality disorder and mood disorder. Psychiatrist #21 indicated the patient had consistent themes of grandiose provocative attention getting behaviors that could place him/her at high risk for acting out and self-injurious behaviors. The consult recommended in part, follow Lithium level for downward trend, nicotine patch and maintain diligent 1:1 arm's length observation given the risk history at this time.

On 1/4/18 Patient #21 was admitted to the in-patient psychiatric unit on a Physician's Emergency Certificate (PEC) with a physician order to provide constant 1 to 1 observation. An admission treatment plan dated 1/4/19 identified an active problem of safety risk/suicide related to overdose on Lithium with interventions to assess suicidality and behaviors, and perform mouth checks. A nurse's note dated 1/4/19 at 7:23 PM indicted that Patient #21 was loud, yelling on the unit, attempting to hurt self, and received Ativan 2 milligrams. An additional nurse's note dated 1/4/19 at 11:01 PM indicated that the patient was argumentative with the evening staff and the patient reported hitting his/her head.

Interview with RN #21 on 1/25/19 at 12:00 PM identified that she could not recall what

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

self-injurious behaviors Patient #21 exhibited and that she did not document Patient #21's behaviors in her note.

An APRN note dated 1/4/19 at 9:05 PM indicted that the APRN was called by the RN at 8:30 PM to assess Patient #21 after he/she intentionally bumped his/her head on the wall repeatedly. Patient #21 was noted to be alert and oriented, following commands and neuro checks were completed per protocol.

Review of the treatment plan failed to address Patient #21's self-harm behavior of bumping head.

On 1/5/19 a physician note indicated that Patient #21 needed a medical evaluation secondary to a bumped head and lower extremity swelling and to rule out a Deep Vein Thrombosis (DVT).

On 1/5/19 at approximately 1:00 PM, Patient #21 was seen in the ED for a medical evaluation which identified no DVT or head injury. An ED psychiatric evaluation dated 1/5/19 at 1:08 PM indicated that Patient #21 had grandiose attention seeking behaviors which placed him/her at high risk for acting out and for self-injurious behaviors and was placed on a 1:1 for safety. The note also indicated that the patient had multiple suicide attempts in the past including using hospital socks as ligatures at another hospital.

A nurse's note dated 1/5/19 at 4:11 PM indicated that Patient #21 informed the ED RN that he/she had swallowed a paperclip a "few hours ago" but was unable to specify a time or where the paperclip was obtained.

A physician note dated 1/5/19 at 7:35 PM indicated that he/she was informed by the nurse that Patient #21 stated he/she swallowed a paper clip on the way to the ED (via ambulance). X-rays were completed that indicated the presence of a paper clip in the left lower abdominal quadrant.

A surgical consult was obtained and indicated no intervention was required, the patient could pass the paperclip.

Interviews with staff identified that they were unable to determine where the paperclip was obtained and/or when the patient swallowed it.

Patient #1 returned to the psychiatric unit on 1/5/19 at 9:05PM.

Review of the treatment plan identified that the patient swallowed a paperclip and reiterated interventions to assess suicidality and behaviors and perform mouth checks.

The treatment plan failed to identify Patient #21's history of using hospital socks as a ligature.

DATES OF VISIT: Commenced on December 15, 2018 and concluded on January 28, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

On 1/10/19 at 9:08 PM, an APRN note indicated that a rapid response was called because Patient #21 wrapped socks around his/her neck. A nurse's (RN #21) note dated 1/10/19 at 9:30 PM indicated that Constant Observer (CO) #21 yelled for help and indicated that Patient #21 had attempted to choke self by tying hospital issued socks around his/her neck. The note indicated that on arrival to the room the patient was alert and oriented, color normal, no cyanosis noted, patient was talking and did not appear in distress.

Interview with CO #21 on 1/24/19 at 11:40 AM indicated that on 1/10/19 she had been relieved for dinner break and upon return Patient #21 was in bed, covered with blankets and facing the window. CO #21 indicated that the patient was quiet for approximately three (3) hours and then she could hear the patient saying "help me", "help me". CO #21 stated she went around the bed, removed the blankets and saw the socks around Patient #1's neck. CO #21 placed her hands under the socks and the socks released immediately.

Interview with the Unit Manager on 1/24/19 at 9:40 AM identified that her expectation was that a constant observer is within arm's length of the patient, and hands, face, and neck are visible.

Review of the suicide precaution policy indicated that for constant observation, maintain visual contact with the patient. The policy failed to outline specific expectations of the constant observer.

Following this incident, Patient #21 was evaluated in the ED. An ED MD note dated 1/10/19 at 9:47 PM indicated that Patient #21's neck was noted to have superficial erythema without any other issues. The MD/RN indicated that the patient explained with a great deal of enthusiasm about his/her suicidal ideation and gleefully explained the decision to strangle self and how he/she tied the socks together. Review of the ED record indicated that Patient #21 was placed on 1:1 immediately on arrival and throughout stay. During the ED stay on 1/10/19, CO #22 provided 1:1/constant observation for Patient #21. Patient #21 was discharged back to the psychiatric unit on 1/11/19 at 1:15 AM.

The treatment plan updated to include Patient #21's behavior of attempting to strangle self with hospital socks.

A nurse's note dated 1/11/19 indicated that upon return from the ED Patient #21 was posturing with the intent to assault and hurt staff. Alternatives to restraints were unsuccessful and Patient #21 was placed in four point restraints on 1/11/19 at 1:45 AM. While in restraints, Patient #21 informed staff that he/she had swallowed a bolt. An MD note dated 1/11/19 at 2:07 AM indicated that Patient #21 claimed he/she swallowed a bolt that was taken from a stretcher while in the ED earlier.

On 1/11/19 at 2:41 AM Patient #21 was sent to the ED for evaluation. An X-ray identified a

DATES OF VISIT: Commenced on December 15, 2018 and concluded on January 28, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

paper clip was in the patient's right pelvic area and a screw was in the patient's stomach. Patient #21 required an endoscopy to remove the screw (previously identified as a bolt) and was treated with a laxative-type preparation to ensure the paperclip was evacuated.

Interview with CO #22 on 1/24/19 at 10:40AM identified that he/she was with Patient #21 in the ED on 1/10/19 into 1/11/19 and indicated that Patient #1's hands were in view "most of the time". CO #22 indicated that the patient did try to lower the side rail of the stretcher but CO #22 stopped him/her from doing so. CO #22 identified that she did not see Patient #22 remove a screw.

Review of facility documentation indicated that on 1/11/19 staff reeducation was completed stressing that staff cannot participate in diversional activities while conducting constant observation, must maintain proper lighting, and includes moving chair to have constant view of the patients face, neck and hands. Education further directed staff to check the bed for any items and have the patient remove socks when getting into bed.